Introduction

Procedure Codes

The Department of Social & Health Services (the Department) uses the following types of procedure codes within these *Physician-Related Services Billing Instructions*:

- Current Procedure Terminology (CPT®); and
- Level II Healthcare Common Procedure Coding System (HCPCS).

Procedures performed must match the description and guidelines from the most current CPT or HCPCS manual for all Department-covered services. **Due to copyright restrictions, the Department publishes only the official brief CPT descriptions. To view the full CPT description, please refer to your current CPT manual.**

Evaluation and Management (E/M) Documentation and Billing

The E/M service is based on key components listed in the CPT manual. Providers must use one of the following guidelines to determine the appropriate level of service:

- The *1995 Documentation Guideline for Evaluation & Management Services* is available online at: www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf.

- The *1997 Documentation Guideline for Evaluation & Management Services* is available online at: www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf.

Once the licensed practitioner chooses either the 1995 or 1997 guidelines, the licensed practitioner must use the same guidelines for the entire visit. Chart notes must contain documentation that justifies the level of service billed.

Diagnosis Codes

The Department requires valid and complete ICD-9-CM diagnosis codes. When billing the Department, use the highest level of specificity (4th or 5th digits when applicable) or the services will be denied.

The Department does not cover the following diagnosis codes when billed as the primary diagnosis:

- E codes (Supplementary Classification);
- M codes (Morphology of Neoplasms); and
- Most V codes.

The Department reimburses providers for only those covered procedure codes and diagnosis codes that are within their scope of practice.

Discontinued Codes

The Department follows Medicare and does not allow providers a 90-day grace period to use discontinued CPT, HCPCS codes. Use of discontinued codes to bill services provided after the date that the codes are discontinued will cause claims to be denied.

Noncovered Services [WAC 388-501-0070]

Procedures that are noncovered are noted with a pound (#) indicator in the Nonfacility Setting (NFS) and Facility Setting (FS) columns in the fee schedule.

The Department reviews requests for noncovered healthcare services according to WAC 388-501-0160 as an Exception to Rule. To request a noncovered service, send a completed "Fax/Written Request Basic Information" form, DSHS #13-756, to the Department (see *Important Contacts* section).

Refer to the current Department/MPA *ProviderOne Billing and Resource Guide* for information regarding noncovered services and billing a Department client who is on a fee-for-service program.

The following are examples of administrative costs and/or services not covered separately by the Department:

- Missed or canceled appointments;
- Preventive medicine services (except EPSDT exams for clients 20 years of age and younger and those clients with developmental disabilities);
- Mileage;
- Take-home drugs;
- Educational supplies or services;
- Copying expenses, reports, client charts, insurance forms;
- Service charges/delinquent payment fees;
- Telephoning for prescription refills;
- Other areas as specified in this fee schedule;
- After-hours charges for services during regularly scheduled work hours.

Who Can Provide and Bill for Physician-Related Services
[WAC 388-531-0250]

The following enrolled providers are eligible to provide and bill for physician-related healthcare services which they provide to eligible clients:

- Advanced Registered Nurse Practitioners (ARNPs);
- Federally Qualified Health Centers (FQHCs);
- Health Departments;
- Hospitals currently licensed by the Department of Health (DOH);
- Independent (outside) laboratories CLIA-certified to perform tests. See WAC 388-531-0800;
- Licensed marriage and family therapists, only as provided in WAC 388-531-1400;
- Licensed mental health counselors, only as provided in WAC 388-531-1400;
- Licensed radiology facilities;
- Licensed social workers, only as provided in WAC 388-531-1400 and 388-531-1600;
- Medicare-certified Ambulatory Surgery Centers (ASCs);
- Medicare-certified Rural Health Clinics (RHCs);
- Providers who have a signed agreement with the Department to provide screening services to eligible persons in the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program;
- Registered Nurse First Assistants (RNFAs); and
- Persons currently licensed by the State of Washington DOH to practice any of the following:

    - ✓ Dentistry;
    - ✓ Medicine and osteopathy;
    - ✓ Nursing;
    - ✓ Optometry; or
    - ✓ Podiatry.

Noncovered Practitioners [WAC 388-531-0250]

The Department does not pay for services performed by any of the following practitioners:

- Acupuncturists;
- Christian Science practitioners or theological healers;
- Counselors (i.e., M.A. and M.S.N.), except as provided in WAC 388-531-1400;
- Herbalists;
- Homeopathists;
- Massage therapists as licensed by the Washington State Department of Health (DOH);
- Naturopaths;
- Sanipractors;
- Social workers, except those who have a master's degree in social work (MSW) and:
  - ✓ Are employed by an FQHC;
  - ✓ Who have received prior authorization from the Department to evaluate a client for bariatric surgery; or
  - ✓ As provided in WAC 388-531-1400.
- Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0010;
- Any other licensed practitioners providing services that the practitioner is not:
  - ✓ Licensed to provide; and
  - ✓ Trained to provide.

Clients Enrolled in the Department's Managed Care Organizations

Many Department clients are enrolled in one of the Department's managed care organizations (MCO). These clients are identified in ProviderOne as being enrolled in an MCO. They also receive an ID card from the MCO in which they are enrolled. Clients enrolled in one of the Department's MCOs must obtain services through their MCO.

> **Note:** A client's enrollment can change monthly. Providers who are not contracted with the plan must receive approval from ***both*** the plan and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's HMO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 388-502-0160.

By Report (BR)

Services with a **BR** indicator in the fee schedule (Section J) with billed charges of $1,100.00 or greater require a detailed report in order to be paid. Attach the report to the claim. **DO NOT** attach a report to the claim for services with a BR indicator in the fee schedule with billed charges under $1,100.00 unless requested by the Department.

Codes for Unlisted Procedures (CPT codes XXX99)

Providers must bill using the appropriate procedure code. The Department does not pay for procedures when they are judged to be less-than-effective (i.e., an experimental procedure), as reported in peer-reviewed literature (see WAC 388-501-0165). If providers bill for a procedure using a code for an unlisted procedure, it is the provider's responsibility to know whether the procedure is effective, safe, and evidence-based. The Department requires this for all its programs, as outlined in WAC 388-501-0050. If a provider does not verify the Department's coverage policy before performing a procedure, the Department may not pay for the procedure.

Acquisition Cost (AC)

Drugs with an **AC** indicator in the fee schedule (Appendix) with billed charges of $1,100.00 or greater, or supplies with billed charges of $50.00 or greater, require a manufacturer's invoice in order to be paid. Attach the invoice to the claim, and if necessary, note the quantity given to the client in the *Comments* section of the claim form. **DO NOT** attach an invoice to the claim for procedure codes with an AC indicator in the fee schedule for drugs with billed charges under $1,100.00, or supplies with billed charges under $50.00, unless requested by the Department.

Note: Bill the Department for one unit of service only when billing for drugs with an AC indicator.

Conversion Factors

	7/1/07	1/1/08	7/1/08	7/1/09	7/1/10
Adult Primary Health Care	21.95	24.58	25.12	22.03	21.96
Anesthesia	21.20	21.20	21.20	21.20	21.20
Children's Primary Health Care	31.82	47.10	47.64	36.48	36.22
Clinical Lab Multiplication Factor	.830	.830	0.820	0.76	00.76
Maternity	42.35	42.35	44.20	43.54	43.50
All Other Procedure Codes	22.03	22.03	22.23	22.31	22.23

These conversion factors are multiplied by the relative value units (RVUs) to establish the rates the Department/MPA Physician-Related Services Fee Schedule.

National Correct Coding Initiative

The Department continues to follow the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists the Department to control improper coding that may lead to inappropriate payment. The Department bases coding policies on:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT®) manual;
- National and local policies and edits;
- Coding guidelines developed by national professional societies;
- The analysis and review of standard medical and surgical practices; and
- Review of current coding practices.

The Department may perform a post-pay review on any claim to ensure compliance with NCCI. NCCI rules will be enforced by the new ProviderOne payment system immediately upon implementation. Visit the NCCI on the web at: http://www.cms.gov/NationalCorrectCodInitEd/NCCIEP/list.asp .

Services by Substitute Physician—How to Bill

The Omnibus Budget Reconciliation Act (OBRA) of 1990 permits physicians to bill under certain circumstances for services provided on a temporary basis (i.e., locum tenens) to their patients by another physician.

The physician's claim must identify the substituting physician providing the temporary services. Complete the claim as follows:

- Enter the substituting physician's NPI in the servicing provider field on the HIPAA transaction (field 24J on the CMS-1500 Claim Form). If you don't know the physician's NPI, enter the physician's name.

- Enter the regular physician's name, address, and NPI the document level field for servicing provider information on the HIPAA transaction (field 33 on the CMS-1500 Claim Form).

- Use modifier Q6 when billing.

Documentation in the patient's record must show that in the case of:

- An informal reciprocal arrangement, billing for temporary services was limited to a period of 14 continuous days, with at least one day elapsing between 14-day periods.

- A locum tenens arrangement involving per diem or other fee-for-time compensation, billing for temporary services was limited to a period of 90 continuous days, with at least 30 days elapsing between 90-day periods.